

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/12/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175159	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/30/2022
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PLACE LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE 8909 PARALLEL PKY KANSAS CITY, KS 66112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS00170140.	F 000			
F 550 SS=D	The 2567 was sent electronically on 04/12/22 Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

04/12/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: The facility identified a census of 34 residents. The sample included 13 residents, with four residents reviewed for dignity. Based on observation, record review, and interviews, the facility failed to acknowledge and honor Resident (R) 18's right for self-determination to sleep undisturbed without feeling interference, or reprisal from the facility staff. The facility further failed to ensure R24's and R25's right to be treated with respect, dignity, and care during meals. These deficient practices placed the residents at risk for negative psychosocial outcomes and decreased autonomy and dignity. Findings included: - R18's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of hypertension (elevated blood pressure), diabetes mellitus (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain). The "Admission Minimum Data Set" (MDS) dated 11/02/21 documented a Brief Interview of Mental	F 550			

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F 550	Continued From page 2 Status (BIMS) score of 13 which indicated intact cognition. The MDS documented R18 was totally dependent of two staff members for activities of daily living (ADL's). The MDS documented R18 required physical assistance of two staff members for bathing during the look back period. The "Quarterly MDS" dated 02/27/22 documented a BIMS score of 13 which indicated intact cognition. The MDS documented R18 required extensive assistance of two staff members for ADL's. The MDS documented R18 was totally dependent of one staff member for bathing during look back period. R18's "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 11/03/21 documented she needed extensive to total assistance with ADL's. R18's "Care Plan" dated 11/02/21 documented social services would meet with her on as needed basis for any psychosocial needs or issues. Review of the EMR under "Progress Notes" tab revealed a note labeled "Behavior Note" dated 02/05/2022 at 01:29 AM. The note documented staff assisted R18 to the bathroom and returned her to bed. At that time R18 requested not to be disturbed until 07:30 AM, so she could sleep undisturbed. Nursing staff encouraged her to allow them to refill her water, stock her with supplies and all other activities including every two-hour check. R18 refused and stated she wanted to sleep. On 03/28/22 at 08:54 AM R18 stated some staff argue with her about her choices related to her activities and her general care. R18 stated she	F 550			

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F 550	Continued From page 3 was afraid to ask for things. On 03/28/22 at 04:13 PM R18 sat in the wheelchair beside her bed., She wore a hospital gown and her bed sheets were pulled back. R18 stated she was not going to bed until 07:00 PM. On 03/30/22 at 01:45 PM in an interview, Certified Nurse's Aide (CNA) M stated all residents should have the right to choose to sleep undisturbed. CNA M went on to say that despite that, she would continue to check on them and make sure they were clean and dry. On 03/30/22 at 02:10 PM in an interview, Licensed Nurse (LN) G stated every resident should have the right to make their own choices, concerning their care. On 03/30/22 at 02:45 PM in an interview, Administrative Nurse D stated residents should be allowed to be allowed to make choices related to their care. The facility "Patient's Rights and Responsibilities" policy last reviewed 12/2017 documented residents have the right to choose activities, schedules and healthcare consistent with his/her interest, assessments and plans of care. The resident's have the right to make choices about aspects of his/her life in the facility that are significant to the resident. The facility failed to ensure staff recognized and honored R18's right for self-determination to sleep undisturbed, without feeling interference or coercion, from the facility staff. This deficient practice placed R18 at risk for impaired dignity and decreased psychosocial well-being.	F 550			

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F 550	Continued From page 4 - R24's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of hypertension (elevated blood pressure), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and dementia (progressive mental disorder characterized by failing memory, confusion). The "Significant Change Minimum Data Set" (MDS) dated 06/30/21 documented a Brief Interview of Mental Status (BIMS) score of six which indicated severely impaired cognition. The MDS documented that R24 required extensive assistance of one staff member for assistance with eating. The "Quarterly MDS" dated 03/11/22 documented a BIMS score of six which indicated severely impaired cognition. The MDS documented R24 required extensive assistance of one staff member for assistance with eating. R24's "Activities of Daily Living Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 07/01/21 documented she required extensive assistance to mostly dependent upon staff for her ADL's. R24's "Nutritional Status" CAA dated 07/01/21 documented a decreased ability to eat independently. R24's "Care Plan" dated 07/01/21 documented she sat at the assisted table in the dining room and may need assistance with meals. On 03/28/22 at 11:58 AM R24 sat upright in a	F 550			

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F 550	Continued From page 5 broda (specialized wheelchair with the ability to tilt and recline) chair in the dining room, Her head hung forward with her glasses resting at the tip of her nose. An unidentified nursing staff member stood next to R24 and assisted her to eat lunch at the assisted table. On 03/29/22 at 12:28 PM R24 sat upright in a broda chair in the dining room. Her head hung forward. An unidentified nursing staff member stood next to R24 and assisted her to eat lunch. On 03/30/22 at 01:45 PM in an interview, Certified Nurse's Aide (CNA) M stated staff availability to assist the residents at the assisted table in the dining varied related to how many CNA's worked that shift. CNA M stated staff should be eye level with residents when staff assisted them with their meals. On 03/30/22 at 02:10 PM in an interview, Licensed Nurse (LN) G stated there was only one CNA in the dining room at the evening meal time to assist the four residents at the assisted table. LN G stated all the other residents are served first so the CNA can assist the residents seated at the assisted table last. LN G stated the CNA sat at the table and assisted each resident one at a time. On 03/30/22 at 02:45 PM in an interview, Administrative Nurse D stated the nursing staff assisting residents with their meals should always be seated next the resident they assisted. The facility "Meal Service" policy with a revision date of 12/30/21 documented nursing staff will assist residents who need assistance with feeding	F 550			

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F 550	Continued From page 6 The facility failed to ensure a dignified dining experience for when staff stood over her instead sitting beside her while assisting with meals. This placed R24 at risk for impaired dignity and decreased psychosocial well-being. - R25's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of major depressive disorder (major mood disorder), dementia (progressive mental disorder characterized by failing memory, confusion), and cirrhosis of the liver (chronic degenerative disease of the liver). The "Significant change Minimum Data Set" (MDS) dated 03/14/22 documented a Brief Interview of Mental Status (BIMS) score of two which indicated severely impaired cognition. The MDS documented R25 required extensive assistance of one staff member for eating during the look back period. R25's "Activities of Daily Living Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 03/17/22 documented she required extensive to total assistance with her ADLs. R25's "Mood State CAA" dated 03/17/22 documented a decline in her mood related to being tired and having a poor appetite. R25's "Nutritional Status CAA" dated 03/17/22 documented she needed more assistance with eating in the dining room at the assisted table. R25's "Care Plan" dated 03/16/22 documented	F 550			

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F 550	Continued From page 7 she was to seat at the assisted table in the dining room for meals. On 03/28/22 at 11:58 AM R25 sat upright in a broda chair in the dining room. An unidentified nursing staff member stood next to R25 and assisted her to eat lunch at the assisted table. On 03/29/22 at 12:28 PM R25 sat upright in a broda chair in the dining room. An unidentified nursing staff member stood next to R25 and assisted her to eat lunch. On 03/30/22 at 01:45 PM in an interview, Certified Nurse's Aide (CNA) M stated staff availability to assist the residents at the assisted table in the dining varied related to how many CNA's worked that shift. CNA M stated staff should be eye level with residents when staff assisted them with their meals. On 03/30/22 at 02:10 PM in an interview, Licensed Nurse (LN) G stated there was only one CNA in the dining room at the evening meal time to assist the four residents at the assisted table. LN G stated all the other residents are served first so the CNA can assist the residents seated at the assisted table last. LN G stated the CNA sat at the table and assisted each resident one at a time. On 03/30/22 at 02:45 PM in an interview, Administrative Nurse D stated the nursing staff assisting residents with their meals should always be seated next the resident they assisted. The facility "Meal Service "policy with a revision date od 12/30/21 documented nursing staff will assist residents who need assistance with	F 550			

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F 550	Continued From page 8 feeding	F 550			
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of	F 655			

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F 655	Continued From page 9 this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: The facility identified a census of 34 resident. The sample included 13 residents with five residents reviewed for baseline care plan. Based on observations, record reviews, and interviews, the facility failed to develop a baseline care plan which included fall interventions for Resident (R)181. This deficient practice placed her at risk for accidents and injury. Findings Included: - The electronic medical record (EMR) documented the following diagnosis for R181: dementia (progressive mental disorder characterized by failing memory, confusion), repeated falls, and difficulty walking. The "Entry Tracking Minimum Data Set" (MDS) recorded R181 admitted to the facility on 03/22/22. R181's "Admission MDS" was in progress on date of review on 03/30/22.	F 655			

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F 655	Continued From page 10 An admission "Fall Assessment" completed on 03/22/22 indicated R181 was a fall risk related to poor balance and gait. A review of R181's "Initial Care Plan" dated 03/22/22 revealed that she was to be evaluated by physical and occupational therapy for falls and she was required to use a wheelchair. The initial care plan indicated she required assistance from one staff for transfers and activities of daily living (ADL's). The initial care plan lacked interventions related to identifying fall risk and interventions. A review of R181's "Incident Note" dated 03/27/22 at 11:50 PM revealed that she was found by staff lying face down on the floor next to her bed. The report indicated that she was tangled in her blanket and unable to lift herself up. The report noted no injuries and the facilities fall protocol was initiated. The note stated R181 was unable to communicate what she was doing at the time of her fall. In an interview completed on 03/30/22 at 01:15 PM Certified Nurses Aid (CNA) M stated that direct care staff utilize a jot sheet that has each resident's information related to care assistance. She reported that the CNA staff do not access to view the care plans. In an interview completed on 03/30/22 at 01:50 PM Licensed Nurse (LN) G stated staff can update care plans by talking to the MDS coordinator and letting them when something has change. She reported that MDS coordinator will update the jot sheet and give them out to staff. In an interview completed on 03/30/22 at 02:30	F 655			

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F 655	Continued From page 11 PM Administrative Nurse D stated that nursing staff are using the jot sheets because the information is pulled directly off the resident's MDS or transferring hospital paperwork. A review of the facility's "Care Plan" policy revised 05/2020 stated an initial care plan will be completed on all residents upon admission and a comprehensive care plan will be developed within 7 days after completion of the comprehensive assessment. The policy indicates that the care plan should include areas triggered in the Care Area Assessment (CAA), assists the resident's care in the facility, and identify potential problems based on the resident's history.	F 655			
F 656 SS=D	The facility failed to provide initial care plan fall interventions for R181. This deficient practice placed her at risk for accidents and injury. Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 656			

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F 656	Continued From page 12 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: - The electronic medical record for R2 documented diagnoses of end stage renal disease (ESRD-medical condition in which the kidneys cease functioning on a permanent basis) and dependent on renal dialysis dated 06/08/21. The "Significant Change Minimum Data Set" (MDS) dated 06/24/21 documented R2 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. He required limited to extensive assist of one staff for his activities of daily living (ADLs). He required the use of a mechanical lift for transfers and a	F 656			

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F 656	Continued From page 13 wheelchair for mobility. Dialysis was not indicated for R2 while not a resident nor while a resident. The "Quarterly MDS" dated 03/15/22 documented R2 had a BIMS score of 15 which indicated intact cognition. He required limited to extensive assist of one staff for ADLs. He used a wheelchair for mobility that he self-propelled. He required dialysis treatment. The "ADL Care Area Assessment" (CAA) dated 06/28/21 documented R2 required extensive assist of one to two staff with his ADLs. Staff used a sit to stand lift for transfers. The "ESRD Care Plan" initiated 06/10/21 documented his dialysis days was Monday, Wednesday and Friday. The care plan directed staff to have R2 ready and to promote eating prior to leaving facility for the treatment. Staff was to monitor R2's vascular access each shift to ensure the dressing was dry and intact. Staff was to also check R2's shunt (a passage that is made to allow blood or other fluid to move from one part of the body to another) for a bruit (a blowing or swishing sound heard which reflects the blood flow with a dialysis resident's shunt), and thrill (a fine vibration felt which reflects the blood flow by a dialysis resident's shunt). The "ESRD Care Plan" lacked documentation of the location and phone number of R2's dialysis treatment, and what time he was scheduled for his dialysis, and how R2 was transported to and from his dialysis appointments. On 03/30/22 at 07:12 AM, R2 self-propelled his wheelchair out of the dining area after eating breakfast. R2 stated "I've got to go to dialysis here after while".	F 656			

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F 656	Continued From page 14 On 03/30/22 at 1:45 PM Certified Nurse Aide CNA M stated that each morning a "JOT" (a printout with info about each resident) sheet was printed out that had all the residents listed on it with the cares, how assistance was need and any appointment a resident might have that day. She stated that there was a book at the nurse's station that had all appointments in it. R2's dialysis days and where he goes should also be in his chart. CNA M stated the MDS person made a new admission checklist when a resident was admitted that told staff what cares or anything special the resident needed. R2 was not on any fluid restriction or special diet that she was aware of due to him being on dialysis. R2 did have to make sure he went to the bathroom before he went to dialysis. Staff tried to get R2's weights on Mondays. If they were not able to get him weighed, staff waited until he returned from his dialysis since the dialysis center weighed him there. CNA M stated the aides did not have access to view or review the care plans of the residents. On 03/30/22 at 2:15 PM Licensed Nurse (LN) G stated that she knew R2 went to dialysis on Monday, Wednesday and Friday, as she was told that he goes when she received report at the beginning of her shift daily. LN G said when R2 returned from his appointment, she would obtain his vital signs and then go get him something to eat. She said facility staff usually made sure he ate breakfast prior to going to his appointment. LN G confirmed R2's care plan should have when and where he went to dialysis. On 03/30/22 at 2:46 PM Administrative Nurse D stated that there should be an order for dialysis	F 656			

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F 656	Continued From page 15 on R2's MAR/TAR that says when he went and where he goes to. Staff nurses had an appointment book at the nurse's station that had all appointments for the residents on it. She further stated the nurses can look at the care plan also to know when R2 went to dialysis. The facility policy "Care Planning and Team Assessment" revised 10/25/17 documented: the resident will receive the benefit of the interdisciplinary team (IDT) approach to the identification of need and plans to assist them to maximize their potential. The care plan included (but not limited to): areas that were triggered and processed with the care plan that is necessary per the CAA process; the team initiates the care plans and develops each problem with special individualized problems, measurable goals, and interventions utilized to assist the resident to improve, develop coping skills or maximize their function; and the care plan is reviewed as a team and revised to reflect the current status of each time there is a new MDS required. The facility policy "Care Plans" last reviewed 05/11/20 documented: the comprehensive care plan will be developed within seven days after the completion of the comprehensive assessment and no later than 21 days from admission. The comprehensive care plan will be completed by the IDT (physician, nursing, social services, dietary, activities, and therapy). The team also includes the patient and family or legal representative in care plan decisions. The comprehensive care plan will be reviewed and revised by the IDT quarterly, annually, and with a significant change. Care plans will be updated through the nursing department when physicians make changes through physician orders.	F 656			

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F 656	Continued From page 16 The facility failed to ensure that R2's care plan for dialysis was updated to include the location, a contact phone number, the time of each appointment, and the transportation information to/from each appointment. This deficient practice had the potential of R2 not receiving the appropriate cares or dialysis treatment needed. The facility identified a census of 34 residents. The sample included 13 residents. Based on observations, record reviews, and interviews, the facility failed to develop a comprehensive care plan to include catheter and skin care prevention for Resident (R)20. The facility further failed to ensure R2's care plan included vital information related to his dialysis (the process of removing excess water and wastes from the blood in people whose kidneys no longer function on their own). This deficient practice placed the residents at risk for complications related to care delivery. Findings Included: -The electronic medical record (EMR) documented the following diagnosis for R20: joint replacement surgery of left hip, chronic respiratory failure with hypoxia (inadequate supply of oxygen), atrial fibrillation (rapid, irregular heart beat), type two diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), chronic kidney disease, hyperlipidemia (condition of elevated blood lipid levels), chronic obstructive pulmonary disease (COPD - progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in	F 656			

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F 656	Continued From page 17 breathing), hypertension (high blood pressure), obstructive sleep apnea (absence of breathing while sleeping), gout (inflammation of the joints), need for assistance with personal care, muscle weakness, and benign prostatic hyperplasia (BPH- non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections). A review of R20's "Admission Minimum Data Set" (MDS) completed 03/03/22 noted a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS indicated that he was admitted on 02/24/22 with two existing stage two pressure ulcers (pressure related skin injury partial thickness). The MDS stated that R20 had a urinary catheter (tube inserted into the bladder to drain urine into a collection bag). R20's "Urinary Incontinence Care Area Assessment (CAA)" completed 03/03/22 identified him at risk for urinary tract infection (UTI) or injuries associated with the use of the urinary catheter secondary to his pre-existing wounds. His "Pressure Ulcer CAA" dated 03/03/22 indicated risks for developing pressure injuries related to decreased mobility, neuropathy (decreased or loss of sensation of touch, pressure, temperature, or pain), and diabetes. The assessment indicated that nursing should complete weekly skin assessments and observe for breakdown during personal cares (including bathing, toileting, and personal hygiene). A review of R20's "Initial Care Plan" created 02/24/22 did not indicate or identify risk related to his stage two ulcers.	F 656			

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F 656	Continued From page 18 A review of R20's "Active Care Plan" indicated that pressure ulcer interventions were added on 03/09/22. The planned interventions included assessing for skin breakdown, applying pressure reducing surfaces, encouragement of nutritional foods, and notifying the medical provider. A review of R20's "Care Plan" also revealed that catheter care interventions were initiated in the care plan on 03/14/22. The interventions included monitoring for discomfort, checking the tubing for kinks, and ensuring that the catheter dignity bag was being utilized. The care plan acknowledged R20 had sustained a stage-three pressure ulcer (full-thickness skin loss potentially extending into the subcutaneous tissue layer) on his penis related to his catheter. The care plan also shows he admitted with two stage-two pressure ulcers on his testicles, and moisture associated skin damage to his buttocks. A review of R20's weekly "Braden Scale" score completed 03/04/22 revealed a moderate risk of 14. A review of R20's "Physician Orders" in his EMR revealed that the order dated 02/24/22 which recorded the urinary catheter was approved the medical provider per R20's request to reduce the episodes of incontinence related to his medical BPH condition. The order stated that staff were to perform catheter care during each shift, change out the catheter monthly, and report skin changes to the physician. A review of R20's "Daily Skilled Charting" dated 03/07/22 at 12:30 PM charted him having edema, bruises, surgical wounds, skin lacerations, and	F 656			

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F 656	Continued From page 19 skin tears present. On 03/08/22 R20 received a new order instructing staff to pull apart and clean the skin folds of his penis two times a day and as needed to promote wound healing. ` A review of R20's "Skin and Wound Care" assessment dated 03/08/22 revealed a stage-three pressure ulcer 4.88 centimeters (cm) in length and 2.13 cm in width located on R20's penis. The note indicated that staff identified the injury while attempting to give him a bed bath that morning. The wound was assessed by Administrative Nurse E on 03/08/22 at 07:36 AM. She noted that R20's mons pubis (pubic area above the penis) was pushing down on his penis and his foley catheter. On 03/30/22 at 07:43 AM R20 received catheter care from Licensed Nurse (LN) H. R20 was positioned in his bed with his brief removed and prepped for catheter care. LN H completed hand hygiene and donned gloves. LN H used her left hand to secure R20's catheter tubing and right hand to clean his genitals going away from his body. In an interview completed on 03/30/22 at 09:55 AM, Administrative Nurse E stated that she found the wound while trying to get R20 to take a bath. Administrative Nurse E stated that R20 was non-compliant with bathing and cares. She reported that when she removed R20's clothing, the skin around his groin was so swollen with edema that it required three staff members to hold his skin apart long enough to see his penis. She stated staff should be assessing his groin area at minimum of at least two times per shift.	F 656			

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F 656	Continued From page 20 Administrative Nurse E reported she believed the edema caused the catheter tubing to rub against R20's sensitive skin, causing the ulcer. In an interview completed on 03/30/22 at 01:15 PM Certified Nurses Aid (CNA) M stated that care staff were required to look at the resident's skin during general cares and report to the nurse if skin issues occur. She reported that the care staff do not have access to look at resident's care plan but receive a "jot" sheet with the resident's information on it. In an interview completed on 03/30/22 at 01:50 PM LN G stated that she had only cared for R20 twice, but he generally allowed staff to care for him. She reported that he did refuse to get up or leave the room sometimes. In an interview completed on 03/30/22 at 02:30 PM Administrative Nurse D stated that nursing staff are using the jot sheets because the information is pulled directly off the resident's MDS or transferring hospital paperwork. She reported that she believes that R20's edema caused his pressure ulcer. A review of the facility's "Skin Assessment" policy revised 04/2020 noted residents will have weekly skin assessments completed by a licensed nurse. Preventive care or active treatment plans will be implements on any impaired skin and reported to the wound care nurse. Care staff will report any sign of skin changes during resident cares to the nurse. A review of the facility's "Skin Integrity and Wound Care Photography" policy reviewed 12/2017 stated the goal of care planning is to provide a	F 656			

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F 656	Continued From page 21 guideline to maintain or improve tissue tolerance in order to prevent injury and to protect from skin breakdown from adverse effects of mechanical forces. The policy stated that staff should routinely check the patient for any pressure ulcers from medical devices a minimum of every shift. A review of the facility's "Foley Catheter Care" revised 04/2020 instructed that catheter care must be provided every shift and as needed every day. The policy indicated that the administration of a catheter may be applied by the facility to assist with wound healing for residents that may have sacral or perineal wounds.	F 656			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility identified a census of 34 residents. The sample included 13 residents with five reviewed for bathing. Based on observations, record reviews, and interviews, the facility failed to provide consistent bathing per the residents' preferences and bathing schedules for Residents (R) 18, and R25. This deficient practice placed the resident at risk for poor hygiene and impaired psychosocial well-being.	F 677			

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F 677	Continued From page 22 Findings included: - R18's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of hypertension (elevated blood pressure), diabetes mellitus (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain). The "Admission Minimum Data Set" (MDS) dated 11/02/21 documented a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented R18 was totally dependent of two staff members for activities of daily living (ADL's). The MDS documented R18 required physical assistance of two staff members for bathing during the look back period. The "Quarterly MDS" dated 02/27/22 documented a BIMS score of 13 which indicated intact cognition. The MDS documented R18 required extensive assistance of two staff members for ADL's. The MDS documented R18 was totally dependent of one staff member for bathing during look back period. R18's "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 11/03/21 documented she needed extensive to total assistance with ADL's. R18's "Care Plan" dated 11/02/21 documented social services would meet with her on as needed basis for any psychosocial needs or issues. The "Care Plan" documented R18 required extensive assistance of one to two staff members with	F 677			

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F 677	Continued From page 23 showering/bathing. The "Care Plan" documented R18 requested no male staff give her a shower/bath. Review of the "Bath and Linen Schedule" revealed R18's scheduled bath/shower times were Thursday and Sunday evening shift. Review of the EMR under "Documentation Survey Reports" tab for bathing reviewed from 01/01/22 to 03/28/22 (86 days) revealed R18 received seven baths/showers (01/16/22, 02/03/22, 02/10/22, 02/17/22, 02/27/22, 03/03/22, and 03/14/22). The "Bathing" task documented "Not Applicable" documented daily on the following dates: 01/01/22-01/15/22, 01/17/22-01/31/22, 02/01/22, 02/02/22, 02/04/22-02/09/22, 02/11/22- 02/16/22, 02/18/22-02/26/22, 02/28/22, 03/01/22, 03/02/22, 03/04/22-03/13/22, 03/15/22-3/28/22. The clinical record lacked documentation of refusals for bathing. On 03/28/22 at 04:13 PM R18 sat in the wheelchair beside her bed. She wore a hospital gown and her bed sheets were pulled back. R18 stated she was not going to bed until 07:00 PM. Her hair appeared oily. On 03/29/22 at 08:47 AM R18 sat in the wheelchair in her room. Her hair remained oily in appearance. R18 stated she felt dirty and bad when she had not received her bath. On 3/30/22 at 01:45 PM in an interview, Certified Nurse's Aide (CNA) M stated staff refer to the posted bath schedule to know which residents were assigned to that shift. CNA M stated that a bath sheet was completed, which was given to	F 677			

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F 677	Continued From page 24 the director of nursing. CNA M stated the bath/shower was also documented in EMR under tasks if the shower/bath was given or refused. CNA M stated she was not aware if R18 ever refused her bath/showers. On 03/30/22 at 02:10 PM in an interview, Licensed Nurse (LN) G stated the CNA's know where to find the bath schedule to find out who's bath/shower was assigned for that shift. LN G stated if a resident refused their bath/shower for CNA's, the nurse would ask the resident why they had refused and encourage the resident to take their bath. LN G stated R18 refused her bath/shower at times. On 03/30/22 at 02:45 PM in an interview, Administrative Nurse D stated every resident should be offered a bath/shower twice weekly. Administrative Nurse D stated if a resident requested a weekly bath or a person was difficult, then their care plan would state that. Administrative Nurse D stated if a resident refused their bath/shower for the CNA, the nurse would ask why the resident had refused. Administrative Nurse D stated alternatives were offered to residents when they refuse. Administrative Nurse D stated R18 preferred only female staff to bath her and the facility tried to observe her request as much as possible. The facility "Showers" policy last reviewed on 12/28/21 documented the facility has a bath schedule to offer at least two baths per week. If a patient requested a bath on unscheduled days, the facility would provide baths as requested. Use bath blankets to protect privacy and keep the resident warm while preparing for the shower and drying off. Charge nurse assigns baths on the	F 677			

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F 677	Continued From page 25 "Daily Assignment Sheet". When the bath was completed the CNA would document "done" and their initials on the "Daily Assignment Sheet". If patient refused a bath the CNA was to offer another time to the patient. If the patient refused two times in one day, then the CNA was to report to the nurse. The nurse would consult with the patient and if the patient still refused the nurse would document. Shower sheet and skin assessment would be completed on every resident who had a scheduled shower. If the resident refused the shower a shower sheet would still be completed. The facility failed to ensure a shower/bath was provided for R18, who required extensive assistance with ADL's, which had the potential to cause skin breakdown and/or skin complications due to poor personal hygiene and impaired psychosocial wellbeing. - R25's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of major depressive disorder (major mood disorder), dementia (progressive mental disorder characterized by failing memory, confusion), and cirrhosis of the liver (chronic degenerative disease of the liver). The "Significant change Minimum Data Set" (MDS) dated 03/14/22 documented a Brief Interview of Mental Status (BIMS) score of two which indicated severely impaired cognition. The MDS documented R25 required assistance of two staff members for physical help in part of the bathing activity during the look back period. R25's "Activities of Daily Living	F 677			

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F 677	Continued From page 26 Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 03/17/22 documented she required extensive to total assistance with her ADLs. R25's "Care Plan" dated 10/06/21 documented she required one to two staff members assistance for bathing/showers. Review of the "Bath and Linen Schedule" revealed R25's scheduled bath/shower times were Thursday and Sunday evening shift. Review of the EMR under "Documentation Survey Reports" tab for bathing reviewed from 01/01/22 to 01/18/22 (18 days) revealed R25 received five baths/showers (01/06/22, 01/09/22, 01/13/22, 01/14/22, and 01/16/22). The "Bathing" task documented "Not Applicable" documented daily on the following dates: 01/01/22, 01/04/22-01/08/22, 01/10/22-01/12/22, 01/15/22, 01/17/22, and 01/18/22. R25 was out of the facility from 01/19/22 to 01/31/22. Review of the "Bathing" tasks reviewed from 02/01/22 to 02/28/22 (28 days) revealed R25 received six baths/showers (02/03/22, 02/07/22, 02/18/22, 02/20/22, 02/24/22, and 02/27/22). "Not Applicable" documented daily on the following dates: 02/01/22, 02/02/22, 02/04/22-02/06/22, 02/08/22-02/17/22, 02/19/22, 02/21/22-02/23/22, 02/25/22, 02/26/22, and 02/28/22. R25 was out of the facility from 03/01/22 to 03/07/22. The "Bathing" task reviewed from 03/08/22 to	F 677			

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F 677	Continued From page 27 03/28/22 (21 days) revealed two baths/showers (03/13/22 and 03/20/22). "Not Applicable" was documented daily on the following dates: 03/08/22-03/12/22, 03/14/22-03/19/22, and 03/21/22-03/28/22. The clinical record lacked any documentation of refusals for bathing. On 03/28/22 at 04:15 PM R25 sat in a reclined broda (specialized wheelchair with the ability to tilt and recline) chair at the nurse's station with her abdomen exposed. R25 had slid down in the chair. On 3/30/22 at 01:45 PM in an interview, Certified Nurse's Aide (CNA) M stated staff refer to the posted bath schedule to know which residents were assigned to that shift. CNA M stated that a bath sheet was completed, which was given to the director of nursing. CNA M stated the bath/shower was documented in EMR under tasks if the shower/bath was given or refused. CNA M stated R25 received a bed bath most of the time because she required two staff members to assist with her bath and most the time they could not take her into the shower room. On 03/30/22 at 02:10 PM in an interview, Licensed Nurse (LN) G stated the CNA's know where to find the bath schedule to find out who's bath/shower was assigned for that shift. LN G stated if a resident refused their bath/shower for CNA's, the nurse would ask the resident why they had refused and encourage the resident to take their bath. LN G stated R25 refused her bath/shower at times and a bed bath was offered when she refused her shower.	F 677			

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F 677	Continued From page 28 On 03/30/22 at 02:45 PM in an interview, Administrative Nurse D stated every resident should be offered a bath/shower twice weekly. Administrative Nurse D stated if a resident requested a weekly bath or a person was difficulty then their care plan would state that. Administrative Nurse D stated if a resident was to refuse their bath/shower for the CNA, the nurse would ask why the resident had refused. Administrative Nurse D stated alternatives are offered to residents when they refuse. Administrative Nurse D stated R25 did refuse at times related to her behavior. The facility "Showers" policy last reviewed on 12/28/21 documented the facility has a bath schedule to offer at least two baths per week. If a patient requested a bath on unscheduled days, the facility would provide baths as requested. Use bath blankets to protect privacy and keep the resident warm while preparing for the shower and drying off. Charge nurse assigns baths on the "Daily Assignment Sheet". When the bath was completed the CNA would document "done" and their initials on the "Daily Assignment Sheet". If patient refused a bath the CNA was to offer another time to the patient. If the patient refused two rimes in one day, then the CNA was to report to the nurse. The nurse would consult with the patient and if the patient still refused the nurse would document. Shower sheet and skin assessment would be completed on every resident who had a scheduled shower. If the resident refused the shower a shower sheet would still be completed. The facility failed to ensure a shower/bath was provided for R25, who required extensive assistance with ADL's, which had the potential to	F 677			

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F 677	Continued From page 29 cause skin breakdown and/or skin complications due to poor personal hygiene and impaired psychosocial wellbeing.	F 677			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 34 residents. The sample included 13 residents, with seven residents reviewed for accidents. Based on observation, record review, and interviews, the facility failed to ensure staff utilized the care planned interventions for Resident (R) 18 to prevent falls and failed to implement appropriate interventions aimed at preventing falls for R25, who was identified as a high fall risk. The facility failed to implement preventative fall measures upon admission as well as appropriate fall interventions immediately after a fall for R181, who was at risk for falls. These deficient practices placed residents at risk for injury related to falls. Findings included: - R18's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of hypertension (elevated blood pressure), diabetes mellitus (when the body cannot use glucose, not enough insulin made, or the body cannot respond	F 689			

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F 689	Continued From page 30 to the insulin), and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain). The "Admission Minimum Data Set" (MDS) dated 11/02/21 documented a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented R18 was totally dependent of two staff members for activities of daily living (ADL's). The MDS documented R18 had falls prior to her admission to the facility and no falls since her admission to the facility. The "Quarterly MDS" dated 02/27/22 documented a BIMS score of 13 which indicated intact cognition. The MDS documented R18 required extensive assistance of two staff members for ADL's. The MDS documented R18 was totally dependent of one staff member for bathing during look back period. The MDS documented R18 had two non-injury falls since admission to the facility. R18's "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 11/03/21 documented she needed extensive to total assistance with ADL's. R18's "Falls Care Area Assessment" (CAA) dated 11/03/21 documented she was at risk for falls related to history of several recent falls, her decreased mobility and right knee pain. Fall precautions were in place. R18's "Care Plan" dated 11/02/21 directed staff to keep walkways and room free from clutter. Keep floors clean and dry. When R18 was in the recliner, make sure she was positioned safely. Check frequently and assist as needed. Ensure	F 689			

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F 689	Continued From page 31 R18 had on non-slip footwear during transfers. Make sure call light and all personal items were within reach. R18's "Care Plan" dated 01/25/22 documented staff were educated to use two staff members with transfers when she was weak. R18's "Care Plan" dated 01/31/22 documented staff offered therapy and if R18 refused, she would be placed on a restorative program to help strengthen her lower extremities. Review of the EMR under the "Progress Notes" revealed a note dated 01/21/22 at 07:17 PM which documented R18 was transferred from wheelchair to bed, lost strength in her legs and was lowered to the floor. No injuries were noted. R18 was transferred into the bed with a Hoyer (total body mechanical lift used to transfer residents) lift. Review of the fall investigation revealed an intervention of two staff member assistance with transfers. Review of the EMR under the "Progress Notes" revealed a note dated 01/22/22 at 08:07 AM R18 insisted on the use of the sit to stand lift related to her fall the previous night. R18 stated she had pain and discomfort in her lower extremities from the fall. R18 was transferred from the bed to the wheelchair with two staff members and gait belt. R18 was then transferred onto the toilet by staff and grab bar. Review of the EMR under the "Progress Notes" revealed a note dated 01/29/22 at 03:45 PM R18 was lowered to the floor in the bathroom during a transfer. No injuries noted. Using a lift from there on would probably be advised as R18 did not	F 689			

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F 689	Continued From page 32 have the strength to assist staff with transferring. Review of the fall investigation report documented R18 would be offered therapy and if refused would be placed on a restorative program. On 03/29/22 at 08:47 AM R18 sat in wheelchair, she stated only one staff member attempted to transfer her on 01/29/22 in the bathroom and she was lowered to the floor. R18 stated staff do not ask her prior to being transferred if she felt strong or weak, if she felt safe with one or two staff members for the transfer. On 03/30/22 at 01:15 PM in an interview, Certified Nurses Aid (CNA) M stated direct care staff utilize a jot sheets that have each resident's care planned information. assistance. CNA M stated if a resident had a fall, she would notify the nurse in charge. CNA M stated she was able to transfer R18 alone during the day but knows as the day went on R18 knees and legs become weaker and she required more assistance with transfers. CNA M stated she knows when R18 needs more assistance with transfers and asks R18 at times if she was weaker. On 03/30/22 at 01:50 PM in an interview, Licensed Nurse (LN) G stated resident that fall were placed on an automatic 72 hours fall protocol and supervised closely. LN G stated the director of nursing during the week and the assisted director of nursing on the weekend update the care plan with the fall interventions. LNG stated she was not sure of any fall interventions in place for R18. On 03/30/22 at 02:30 PM in an interview, Administrative Nurse D stated that nursing staff	F 689			

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F 689	Continued From page 33 are using the jot sheets because the information is pulled directly off the resident's MDS or transferring hospital paperwork. Administrative Nurse D stated R18 refused therapy most times when offered but had finally agreed to work allow restorative to work with her for strengthening. A review of the facility's "Fall Prevention and Management Protocol" policy revised 12/2021 stated that all resident will be assessed for risk factors and individualized interventions will be added to the resident care plan. The facility failed to ensure the interventions determined by the director of nursing to be helpful in preventing future falls for R18 were implement by the staff, which placed R18 at risk of possible major injury from falls. - R25's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of major depressive disorder (major mood disorder), dementia (progressive mental disorder characterized by failing memory, confusion), and cirrhosis of the liver (chronic degenerative disease of the liver). The "Significant Change Minimum Data Set" (MDS) dated 03/14/22 documented a Brief Interview of Mental Status (BIMS) score of two which indicated severely impaired cognition. The MDS documented R25 required extensive assistance of one staff member for eating during the look back period. The MDS documented one non-injury fall for R25 during the look back period. R25's "Activities of Daily Living Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 03/17/22 documented	F 689			

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F 689	Continued From page 34 she required extensive to total assistance with her ADLs. R25's " Falls Care Area Assessment" (CAA) dated 03/17/22 documented she was at risk for falls related to decreased mobility, history of falls and her impaired cognition. R25 had a fall on the day of admission to the facility. Fall precautions were in place. R25's "Care Plan" dated 10/05/21 documented to make sure non-slip footwear on during transfers. Make sure fresh water was in reach for R25. Make sure Dycem (a rubber mat that prevents objects from sliding) was in the wheelchair and R25 was reminded to use the call light for transfers. Always keep room free of clutter and clean. Keep floors clean and dry. R25's "Care Plan" dated 10/11/21 documented she was reeducated on to use the light for assistance with transfer and toileting. R25's "Care Plan" dated 10/18/21 documented call light was decorated and R25 was reminded to use call light for assistance. R25's "Care Plan" dated 10/23/21 documented therapy to work with R18 for safe positioning in wheelchair. R26's "Care Plan" dated 11/22/21 documented a sign was placed in the bathroom to remind R25 to call for assistance. R25's "Care Plan" dated 12/07/21 documented lab work for ammonia level. R25 was reeducated to use the call light to call for assistance. Wheelchair to be kept within reach when in bed.	F 689			

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F 689	Continued From page 35 R25's "Care Plan" dated 12/20/22 documented brake extenders placed on wheelchair and R25 removed the brake extenders at times. R25's "Care Plan" dated 12/28/21 documented an evaluation of ADL's and transfer to determine proper staff and equipment. R25's "Care Plan" dated 03/09/22 documented returned from recent hospital stay and was beginning a skilled stay with therapy orders. Review of the EMR under "Progress Notes" tab revealed a note dated 10/04/21 at 06:25 PM which documented R25 was found on the floor in and upright position next to the bed in her room. No injuries noted. Encouraged R25 to use the call light for assistance. Review of the fall investigation revealed an intervention for Dycem to be placed in wheelchair. Review of the EMR under "Progress Notes" tab revealed a note dated 10/07/21 at 05:30 AM which documented R25 was found face down on the floor next to her bed. R25 received a skin tear on left elbow and lacerations on buttocks. Make sure items are within R25's reach and practice use of call light to call for assistance. Review of the fall investigation revealed intervention of lab work to be obtained. Review of the EMR under "Progress Notes" tab revealed a note dated 10/10/21 at 09:09 AM which documented R25 had an unwitnessed non-injury fall in the bathroom. Fall investigation revealed intervention for R25 to be encouraged to use call light.	F 689			

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F 689	Continued From page 36 Review of the EMR under "Progress Notes" tab revealed a note dated 10/12/21 at 01:18 PM which documented R25 had an unwitnessed fall in her room. Skin tear noted on her left buttocks. Review of the fall investigation revealed room move closer to the nurse's station. Review of the EMR under "Progress Notes" tab revealed a note dated 10/16/21 at 07:00 PM which documented R25 had unwitnessed fall in her room, was found sitting upright in front of her wheelchair. R25 needs to use call light for assistance. Review of the fall investigation revealed intervention call light to be decorated. Review of the EMR under "Progress Notes" tab lacked a note for unwitnessed fall, on 10/02/21. Review of the fall investigation R25 was found on the floor in her room. Fall intervention was for a medication review and lab work to be obtained. Review of the EMR under "Progress Notes" tab revealed a note dated 11/18/21 at 01:35 PM which documented R25 was found on the bathroom floor on her back twice today at 07:30 AM and 10:30 AM. Skin tear noted on left arm and hematoma on the back of her head. Reminded R25 to use her call light to call for assistance. Review of the fall investigation revealed intervention to decorate the bathroom call light and sign in the bathroom. Review of the EMR under "Progress Notes" tab revealed a note dated 12/25/21 at 11:45 AM which documented R25 was lowered to her knees during a transfer from the bed to the wheelchair. Staff attempted to transfer R25 and she was unable to follow instructions during the transfer, R25 was lowered to the floor. Staff then	F 689			

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F 689	Continued From page 37 attempted to use stand up lift R25 was unable to follow instructions, R25 let go of the handles on the lift and again was lowered to the floor as slipped out of the sling. R25 become agitated. Two staff then lifted R25 manually from the floor, R25 leaned forward and grabbed the lift as she stood up and R25 refused to release the lift as the staff lowered her to the floor again. Three staff members lifted R25 off the floor and into the wheelchair. Review of the fall investigation revealed intervention of reminders for R25 to use her call light and keep her wheelchair close to her bed. Review of the EMR under "Progress Notes" tab revealed a note dated 12/06/21 at 07:00 PM which documented R25 had an unwitnessed fall in her bathroom, found sitting on the floor facing the toilet. Scrape noted on right elbow. R25 encouraged to use the call light. Review of the fall investigation revealed interventions for lab work for ammonia level. Review of the EMR under "Progress Notes" tab revealed a note dated 12/19/21 at 02:33 PM which documented R25 had an unwitnessed fall in the bathroom doorway, found face down on the floor. Review of the fall investigation revealed and intervention for brake extenders to be placed on R25's wheelchair. Review of the EMR under "Progress Notes" tab revealed a note dated 12/25/21 at 09:53 AM which documented R25 was lowered to the floor by staff during a transfer. No injuries noted. Review of the fall investigation revealed intervention for an evaluation for ADL and transfers to determine the proper staff and equipment to used during transfers.	F 689			

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F 689	Continued From page 38 Review of the EMR under "Progress Notes" tab revealed a note dated 03/07/22 at 11:28 PM which documented R25 had an unwitnessed fall in her room. No injuries noted. Review of the fall investigation revealed intervention for a therapy evaluation. On 03/28/22 at 04:15 PM R25 sat in a reclined broda (specialized wheelchair with the ability to tilt and recline) chair at the nurse's station with her abdomen exposed. R25 had slid down in the chair. On 03/30/22 at 01:15 PM in an interview, Certified Nurses Aid (CNA) M stated direct care staff utilize a jot sheets that have each resident's care planned information. assistance. CNA M stated if a resident had a fall, she would notify the nurse in charge. CNA M stated R25 required Dycem in chair to help prevent her from sliding down. On 03/30/22 at 01:50 PM in an interview, Licensed Nurse (LN) G stated resident that fell were placed on an automatic 72 hours fall protocol and supervised closely. LN G stated the director of nursing during the week and the assisted director of nursing on the weekend update the care plan with the fall interventions. LN G stated R25 did not always understand or remember the reminders, and R25's lab work was now scheduled every two weeks to monitor her ammonia levels related to her diagnosis of cirrhosis of the liver. On 03/30/22 at 02:30 PM in an interview, Administrative Nurse D stated that nursing staff are using the jot sheets because the information is pulled directly off the resident's MDS or	F 689			

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F 689	Continued From page 39 transferring hospital paperwork. Administrative Nurse D stated R25 had some behaviors at times, and said some days R25 was able to understand reminders and instructions but other days she was not. A review of the facility's "Fall Prevention and Management Protocol" policy revised 12/2021 stated that all resident will be assessed for risk factors and individualized interventions will be added to the resident care plan. The facility failed to develop an appropriate interventions to prevent falls for R25, who had multiple falls. This placed R25 at increased risk for major injuries related to falls. - The electronic medical record (EMR) documented the following diagnosis for R181: dementia (progressive mental disorder characterized by failing memory, confusion), repeated falls, and difficulty walking. The "Entry Tracking Minimum Data Set" (MDS) recorded R181 admitted to the facility on 03/22/22. R181's "Admission MDS" was in progress on date of review on 03/30/22. An admission "Fall Assessment" completed on 03/22/22 indicated she was a fall risk related to poor balance and gait. A review of R181's "Initial Care Plan" dated 03/22/22 revealed that she was to be evaluated by physical and occupational therapy for falls and she was required to use a wheelchair. The initial care plan indicated she required assistance from	F 689			

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F 689	Continued From page 40 one staff for transfers and activities of daily living (ADL's). The initial care plan lacked interventions related to identifying fall risk and interventions. A review of R181's "Incident Note" dated 03/27/22 at 11:50 PM revealed that she was found by staff lying face down on the floor next to her bed. The report indicated that she was tangled in her blanket and unable to lift herself up. The report noted no injuries and the facilities fall protocol was initiated. The note stated R181 was unable to communicate what she was doing at the time of her fall. A review of the "72 Hour Follow Up" assessment 03/29/22 revealed the resident appeared to have no injury or discomfort noted by staff. The resident reported no concerns. Interventions were added to R181's plan of care 03/29/22. The listed interventions included reminders to utilize her call light for assistance, ensure she is wearing non-slip footwear, ensure safe positioning while in recliner, and ensure floors are free from clutter. The care plan noted that R181 was alert to self only. In an interview completed on 03/30/22 at 01:15 PM Certified Nurses Aid (CNA) M stated that direct care staff utilized a jot sheet that has each resident's information related to care assistance. She reported that if a resident fell, the nurse will assess the resident and determine the cause of the fall. She noted that the resident will be put on a 72 hour fall follow-up and staff will monitor the resident closely. In an interview completed on 03/30/22 at 01:50 PM Licensed Nurse (LN) G stated that resident	F 689			

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F 689	Continued From page 41 that fall will be placed on an automatic 72 hours fall protocol and supervised closely. If an intervention needs to be address or added to the resident's care, the nurse will report it to the MDS coordinator, and it will be added to the jot sheet. In an interview completed on 03/30/22 at 02:30 PM Administrative Nurse D stated that nursing staff are using the jot sheets because the information is pulled directly off the resident's MDS or transferring hospital paperwork. She stated that the facility has a fall protocol that the nurses will initiate if a resident fall. The nurse must assess the resident and complete neurological checks if the resident hit their head or the fall was unwitnessed. The fall information was collected and reviewed by the team to determine is other intervention need to be implemented. A review of the facility's "Fall Prevention and Management Protocol" policy revised 12/2021 stated that all resident will be assessed for risk factors and individualized interventions will be added to the resident care plan. The facility failed to implement preventative fall measures upon admission as well as appropriate fall interventions immediately after a fall for R181, who was at risk for falls. This deficient practice placed her at risk for fall related injury.	F 689			
F 691 SS=D	Colostomy, Urostomy, or Ileostomy Care CFR(s): 483.25(f) §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy	F 691			

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F 691	Continued From page 42 services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: The facility identified a census of 34 residents. The sample included 13 residents. One resident, Resident (R) 129, was sampled for ileostomy (a surgical formation of an opening through which fecal matter emptied) care. Based on observation, record review and interview, the facility failed to ensure a physician's order for ileostomy care (when to change, how often to change, how often to check the ostomy) and appropriate application of the necessary cares. This deficient practice left R129 at risk for complications related to the ileostomy such as infection and skin breakdown. Findings included: - The electronic medical record (EMR) for R129 documented diagnoses of surgical aftercare following surgery on the digestive system, and ileostomy. R129's "Admission Minimum Data Set" (MDS) was in progress as she was admitted on 03/24/22. R129's "Care Area Assessment" was in progress. The "Ileostomy Care Plan" initiated 03/28/22 documented/directed staff to: assess stoma (an artificial opening in the abdomen) site and surrounding skin with each pouch change; encourage resident to take active part in the daily care of emptying and cleaning bag; and have	F 691			

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F 691	Continued From page 43 resident and/or care giver demonstrate and assist as needed with future pouch changes. Instruct staff on how to apply ileostomy bag as follows: a) clean stoma and peri stoma; b) size stoma for appropriate sized appliance; c) apply skin prep around the stoma site if there is any redness around the stoma and to protect against fecal matter; d) make sure skin is totally dry before applying the pouch; f) change bag every five to seven days as needed. The "Care Plan" lacked documentation of the size and type of appliance required. The March 2022 "Medication Administration Record" (MAR) and "Treatment Administration Record" (TAR) lacked evidence of the ileostomy care (when to change, how often to change, and monitoring) provided. On 03/28/22 at 09:06 AM R129 stated that since she was admitted on 03/24/22 the staff have not been able to get a good seal on the skin for her ileostomy, so it had been leaking and needed to be changed numerous times. On 03/30/22 at 09:11 AM R129 sat in her wheelchair in her room wearing a hospital type gown., R129 stated that some staff were able to get a seal on her ostomy bag a few times, but it did not last for very long. R129 stated that in the last day or so staff have had to change the ostomy bag over a half a dozen times. R129 stated that Administrative Nurse E tried to figure out a solution to get the bag to seal. R129 stated she not sure she could deal with that mess on her own. She stated she had to wear a hospital gown all the time because the bag was always leaking. On 03/30/22 at 1:45 PM Certified Nurse Aide	F 691			

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F 691	Continued From page 44 (CNA) M stated that the aides were able to empty the ostomy bags, but the nurse had to change the bag. Staff had to change the bag numerous times in the last couple of days because the bag had been leaking. The aide was responsible for emptying and checking the bag each shift. CNA M was not sure if staff documented when the bag was changed. On 03/30/22 at Licensed Nurse (LN) G stated that R129's ileostomy bag and stoma were cleaned and changed by the wound nurse yesterday. Staff had to put an abdominal (ABD) pad around the area and tape it to keep the bag from leaking so much. LN G stated there should be scheduled days in the care plan and on the MAR and TAR when to check and change the bag and what equipment/appliance should be used. On 03/30/22 at 02:46 PM Administrative Nurse D stated that there should be something entered on the MAR or TAR that directs staff when to change the ileostomy bag and what size was required. The bag should be checked and emptied each shift. The wound nurse was here yesterday and changed everything but R129's skin was becoming excoriated and the wafer around the stoma was not staying sealed to the skin, so the ostomy keeps leaking. They plan on consulting the surgeon for further guidance. The facility lacked a policy for ileostomy care. The facility failed to ensure that staff gave the necessary care and services related to ileostomy care for R129. This placed her at risk for ostomy related complications.	F 691			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning	F 695			

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F 695	Continued From page 45 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: The facility identified a census of 34 residents. The sample included 13 residents. Four residents were sampled for respiratory care. Based on observation, record review, and interview, the facility failed to ensure that staff provided the necessary respiratory care and services when staff failed to properly change, dated and stored oxygen (O2) tubing when not in use for resident (R)130 and R20, which left these resident at risk for unwarranted respiratory complications. Findings included: - The electronic medical record (EMR) for R130 document diagnoses of chronic obstructive pulmonary disease (COPD-a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), pulmonary fibrosis (a lung disease that occurs when lung tissue becomes damaged an scarred, and pneumonia (inflammation of the lungs). The "Admission Minimum Data Set" (MDS) dated 03/25/22 documented a Brief Interview for Mental Status (BIMS) score of 15. He required extensive	F 695			

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F 695	Continued From page 46 assistance of one staff with his activities of daily living (ADLs). He required oxygen O2 therapy and the use of a BiPap (non-invasive mechanical ventilator device to aide in breathing). The "ADLs Care Area Assessment" (CAA) dated 03/29/21 documented R130 returned from a recent hospital visit with a diagnosis of pneumonia. The "Altered Respiratory Status Care Plan" initiated 03/23/22 directed staff to provide O2 as ordered; to monitor for signs/symptoms of respiratory distress and report to the physician as needed; to monitor/document/report abnormal breathing patterns to the physician; he has a Bipap that he brought from home and was supposed to wear it every night, but most of the time, he refused to put it on. The care plan lacked staff direction for O2 tubing care and when it was scheduled to be changed or to document when it was changed. The care plan lacked staff direction for BiPap care/cleaning. The "Order Summary Report" documented an order dated 03/18/22 for O2 at four liters per nasal canula (NC). The "Order Summary Report" documented an order dated 03/21/22 for BiPap at night every night shift. The "Medication Administration Record" (MAR) and the "Treatment Administration Record" (TAR) for the month of March 2022 lacked documentation of the O2 therapy order and documentation of when O2 tubing should be changed, or when the BiPap should be cleaned.	F 695			

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F 695	Continued From page 47 On 03/28/22 at 11:19 AM R130 sat in his wheelchair in his room and had his O2 on per NC via portable O2 tank on the back of his wheelchair. His O2 concentrator (a machine used to provide supplemental O2) was in his bathroom, the undated tubing and NC connected to the concentrator laid on the bedside table in his room uncovered. On 03/30/22 at 10:04 AM an observation revealed R130's undated O2 tubing/NC from his concentrator was lying on R130's floor. At this time licensed nurse (LN) H came into the room, picked up the dirty tubing and threw it away and left the room to retrieve new tubing. R130 sat in his wheelchair in his room and did not have his O2 on. On 03/30/22 at 01:45PM Certified Nurse Aide (CNA) M stated the O2 tubing was changed and dated every Sunday during the night shift as well as the water bottle on the concentrator. CNA M stated she was not sure if it was documented anywhere on the days that the tubing was changed. Administrative Nurse D usually went around the facility the next few days to check to make sure that the tubing was changed. On 03/30/22 at 02:15 PM LN G stated that O2 tubing should be stored in a bag and dated when not being used. The tubing should be changed on Sundays by the night shift staff. LN G was not sure if staff documented anywhere when the O2 tubing had been changed. On 03/30/22 at 02:46 PM Administrative Nurse D stated that the O2 tubing should be changed every Sunday night on the night shift and the new tubing should be dated. When not in use the	F 695			

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F 695	Continued From page 48 tubing should be stored in a bag on the concentrator. She would expect staff to change the tubing if they had found it not in the bag or on the floor. Staff should wash/rinse the BiPap hose after it is used. Administrative Nurse D stated she did not believe that staff documented anywhere when the O2 tubing was changed. The "Oxygen Therapy and Care of Oxygen Equipment" policy last revised 04/29/20 documented: controlled concentration of oxygen will be delivered in an accurate, safe, and clinically approved manner. Oxygen equipment will be maintained and care for appropriately; at the time of initiation, O2 tubing, either NC or mask, will be labeled the day it is started; O2 tubing will be changed weekly by night shift and as needed as cleanliness demands; if possible, the same tubing will be used for both the concentrator and the E-tank (portable O2 tank); if there is O2 tubing that is not being used, it is to be placed in a plastic bag on the concentrator or the back of the wheelchair; and if tubing becomes contaminated clean with sanitizer. The policy lacked documentation regarding cleaning/care for the BiPap machine. The facility failed to ensure that staff properly dated and stored the O2 tubing and failed to ensure tracked when the O2 tubing was changed for R130. This deficient practice left R130 vulnerable for respiratory complications. -The electronic medical record (EMR) documented the following diagnosis for R20: joint replacement surgery of left hip, chronic respiratory failure with hypoxia (inadequate supply of oxygen), atrial fibrillation (rapid, irregular heart beat), type two diabetes (when the body	F 695			

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F 695	Continued From page 49 cannot use glucose, not enough insulin made or the body cannot respond to the insulin), chronic kidney disease, hyperlipidemia (condition of elevated blood lipid levels), chronic obstructive pulmonary disease (COPD - progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), hypertension (high blood pressure), obstructive sleep apnea (absence of breathing while sleeping), gout (inflammation of the joints), need for assistance with personal care, muscle weakness, and benign prostatic hyperplasia (BPH- non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections). A review of R20's "Admission Minimum Data Set" (MDS) completed 03/03/22 noted a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS indicated he required extensive assistance completing bathing, toileting, transfers, and grooming. A review of R20's "Active Care Plan" dated 03/14/22 indicated oxygen therapy was prescribed related to his COPD and respiratory conditions. The plan stated to give oxygen as prescribed and monitor for symptoms related to respiratory failure. A review of R20's "Physician Orders" in his EMR revealed that the order dated 02/25/22 stated that oxygen tubing and nebulizer mouthpiece were changed out weekly every Sunday evening. On 03/28/22 at 10:20 AM the unbagged oxygen tubing and nasal cannula were observed on the soiled pad on R20's bed. Inspection of the tubing	F 695			

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F 695	Continued From page 50 lacked indication of when the tubing was last placed. On 03/28/22 at 11:20 AM the unbagged, undated oxygen tubing was observed hanging off the resident bed over the trash can in his room. Inspection of the tubing revealed a new sticker but no date on the sticker. On 03/29/22 at 07:54 AM the unbagged oxygen tubing and nasal cannula were observed on the floor as staff were escorting the resident out of the room to go to the dining hall for breakfast. Inspection of the oxygen tubing revealed the sticker was dated 03/28/22. In an interview completed on 03/30/22 at 01:15 PM Certified Nurses Aid (CNA) M stated that the CNA staff are responsible for ensuring that the oxygen care equipment are clean and remain sanitary. She reported that when not in use the cannula and tubing should be stored hygienically in a bag on the machine. She reported that the equipment should never be placed on dirty surfaces. She reported that the tubing and cannula's get changed out every Sunday evening. In an interview completed on 03/30/22 at 01:50 PM Licensed Nurse (LN) G stated that the nurses will check the machines and tubing daily to ensure it is being properly cleaned and stored. She reported that if a cannula touches the floor it must be replaced with a clean one. A review of the facility's "Oxygen Therapy and Care of Equipment Policy" revised 04/2020 stated that the tubing will be labeled the day is started and changed out weekly by night shift. The policy states that when the tubing or cannula is not	F 695			

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F 695	Continued From page 51 being used it must be stored in a plastic bag on the concentrator. The policy indicates contaminated equipment must be cleaned with sanitizer or replaced. The facility failed properly date and store R20's oxygen tubing in a hygienic manner. This deficient practice placed the resident at risk for complications related to respiratory therapy.	F 695			
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: The facility identified a census of 34 residents. The sample included 13 residents. One resident was sampled for dialysis (the process of removing excess water and wastes from the blood in people whose kidneys no longer function on their own) care. Based on observation, record review and interview, the facility failed to ensure that Resident (R)2 had a physician's order for dialysis and failed to ensure critical information such as the name and location of the dialysis center, a contact number, the time of treatment and transportation to/from the dialysis clinic was documented on R2's clincial record. This deficient practice left R2 at risk for improper care and treatment. Findings included:	F 698			

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F 698	Continued From page 52 - The electronic medical record (EMR) for R2 documented diagnoses of end stage renal disease (ESRD) (ESRD-medical condition in which the kidneys cease functioning on a permanent basis) and dependent on renal dialysis dated 06/08/21. The "Significant Change Minimum Data Set" (MDS) dated 06/24/21 documented R2 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. He required limited to extensive assist of one staff for his activities of daily living (ADLs). He required the used of a mechanical lift for transfers and a wheelchair for mobility. Dialysis was not indicated for R2 while not a resident nor while a resident. The "Quarterly MDS" dated 03/15/22 documented R2 had a BIMS score of 15 which indicated intact cognition. He required limited to extensive assist of one staff for ADLs. He used a wheelchair for mobility that he self-propelled. He received dialysis treatment. The "ADL Care Area Assessment" (CAA) dated 06/28/21 documented R2 required extensive assist of one to two staff with his ADLs. Staff used a sit to stand lift for transfers The "ESRD Care Plan" initiated 06/10/21 documented his dialysis days were Monday, Wednesday and Friday. The care plan directed staff to have R2 ready and to promote eating prior to leaving facility for the treatment. Staff were to monitor R2's vascular access each shift to ensure the dressing was dry and intact. Staff were to check R2's shunt (a passage that is made to allow blood or other fluid to move from one part of the body to another) for a bruit (a	F 698			

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F 698	Continued From page 53 blowing or swishing sound heard which reflects the blood flow with a dialysis resident's shunt), and thrill (a fine vibration felt which reflects the blood flow by a dialysis resident's shunt). The "ESRD Care Plan" lacked documentation of the location and phone number of R2's dialysis treatment, and what time he was scheduled for his dialysis, and how R2 was transported to and from his dialysis appointments. R2's Medication Administration Record (MARs) reviewed for December 2021, January 2022, February 2022 and March 2022 and "Order Summary Report" lacked a physician's order for dialysis. On 03/30/22 at 07:12 AM, R2 self-propelled his wheelchair out of the dining area after eating breakfast. R2 stated "I've got to go to dialysis here after while". On 03/30/22 at 1:45 PM Certified Nurse Aide CNA M stated that each morning a "JOT" (a printout with info about each resident) sheet was printed out that had all the residents listed on it with the cares, how much assistance was needed, and any appointment a resident might have that day. She stated that there was a book at the nurse's station that had all appointments in it. R2's dialysis days and where he goes should also be in his chart. CNA M stated the MDS person made a new admission checklist when a resident was admitted that told staff what cares or anything special the resident needed. R2 was not on any fluid restriction or special diet that she was aware of. R2 did have to make sure he went to the bathroom before he went to dialysis. Staff tried to get R2's weights on Mondays. If they were not able to get him weighed, staff waited until he	F 698			

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F 698	Continued From page 54 returned from his dialysis since the dialysis center weighed him there. CNA M stated the aides did not have access to view or review the care plans of the residents. On 03/30/22 at 2:15 PM Licensed Nurse (LN) G stated that she knew R2 went to dialysis on Monday, Wednesday and Friday, as she was told that he goes when she received report at the beginning of her shift daily. She stated she did not see an order for dialysis on the MAR, she just knew that he goes because the days he goes was written down on the appointment book at the nurse's station. LN G said when R2 returned from his appointment, she would obtain his vital signs and then go get him something to eat. She said facility staff usually made sure he ate breakfast prior to going to his appointment. On 03/30/22 at 2:46 PM Administrative Nurse D stated that there should be an order for dialysis on R2's MAR/TAR that says when he went and where he goes to. Staff nurses had an appointment book at the nurse's station that had all appointments for the residents on it. She further stated the nurses can look at the care plan also to know when R2 went to dialysis. The facility failed to provide a policy regarding dialysis orders. The facility failed to ensure that a physician's order for dialysis treatment and failed to ensure R2's EMR contained information that included the address of the facility providing dialysis service, a contact phone number, and time of each appointment. This deficient practice placed R2 at risk for inappropriate cares related to dialysis treatment.	F 698			

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F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to:	F 880			

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F 880	Continued From page 56 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The facility identified a census of 34 residents. Based on observations, record reviews, and interviews, the facility failed to ensure appropriate hand hygiene during dining service; the facility failed store respiratory equipment in a sanitary manner; and the facility failed to maintain sanitary handling of clean linen. This placed the affected residents at increased risk for infections. Findings Include:	F 880			

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F 880	Continued From page 57 - On 03/28/22 at 09:18 AM an observation of R20's room revealed his oxygen tubing and nasal cannula (breathing device that delivers concentrated oxygen into both nostrils) lying on top of his soiled bed pad on his bed. An inspection of R20's oxygen concentrator (machine that delivers measurable prescribed oxygen to residents) revealed that the concentrator had no bag for storing the cannula or date indicating how long the tubing has been in use. R20's dirty bed linen blanket, heel floats, and soiled pillow were placed directly on top of his recliner in his room. An observation of R20's floor revealed two bloody cotton balls and a used diabetic (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) blood glucose test strip (test used to check to level of glucose within a drop of blood) on the floor next to his bed. On 03/28/22 at 09:45 AM observation revealed the 100 hallway "Clean Linen" storage closet was propped fully open with no barrier/cover between the clean linen and the care facility environment. On 03/28/22 at 10:30 AM observation revealed facility staff transported clean linen between different hallways in a black cart without a cover to protect the clean linen from the care facility environment. On 03/28/22 at 01:21 PM R26's oxygen concentrator tubing laid on the side of his bed with the nasal cannula hanging directly above the trash can and the tubing touching the rim of the trash can. On 03/28/22 at 11:45 AM an observation of the facility's lunch service was completed. The	F 880			

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F 880	Continued From page 58 observation revealed multiple staff members touching residents, their wheelchairs, and the facility environment without completing hand hygiene in between assists. An observation of meal distribution revealed multiple staff passing out resident's meals and drinks without completing hand hygiene in between each serving. Staff was observed touching the residents, dining environment, and wheelchairs without completing hand hygiene between the assists. On 03/29/22 at 07:54 AM an observation of R20's room revealed his nasal cannula and oxygen tubing laid on the center of the floor in his room along with another used diabetic glucose test strip. R20's restroom contained two used gloves in his sink and a trashcan full of soiled gloves and medical pads. R20's soiled bed linen were in his recliner. In an interview completed on 03/29/22 at 09:44 AM, Housekeeping U stated that all laundry was transported using the covered cart. She stated that the soiled laundry was bagged and separated in the soiled linen room. She reported that all linen closets should remain closed and should only be opened temporarily when removing needed items. In an interview completed on 03/30/22 at 01:15 PM Certified Nurses Aid (CNA) M stated that the CNA staff are responsible for ensuring that the oxygen delivery equipment is clean and remain sanitary. She reported that when not in use the cannula and tubing should be stored hygienically in a bag on the machine. She reported the equipment should never be placed on dirty surfaces. She reported that the tubing and	F 880			

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F 880	Continued From page 59 cannula's get changed out every Sunday evening. She reported that staff should be completing hand hygiene when assisting residents, serving food, when soiled or after removing gloves. In an interview completed on 03/30/22 at 01:50 PM Licensed Nurse (LN) G stated that the nurses will check the machines and tubing daily to ensure it is being properly cleaned and stored. She reported that if a cannula touches the floor it must be replaced with a clean one. She reported that staff are required to complete hand hygiene when helping resident, feeding and serving, and anytime staff have come in direct contact with the care environment. A review of the facility's "Oxygen Therapy and Care of Equipment Policy" revised 04/2020 stated that the tubing will be labeled the day is started and changed out weekly by night shift. The policy states that when the tubing or cannula is not being used it must be stored in a plastic bag on the concentrator. The policy indicates contaminated equipment must be cleaned with sanitizer or replaced. A review of the facility's "Hand Hygiene" policy revised 04/2020 stated that staff are required to complete hand hygiene before and after contacting the resident, environment, or when completing direct care to the resident. A review of the facility's "Laundry Services" policy revised 04/2020 stated the all clean linen must be handled, transported, and stored in a manner that prevents contamination from the care environment. The policed indicates that clean linen must be transported with a covered cart to prevent contamination.	F 880			

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F 880	Continued From page 60 The facility failed to ensure appropriate hand hygiene during dining service; The facility failed to prevent the contamination of resident's medical equipment and care environment; and failed to maintain sanitary handling of clean linen.	F 880			